DMS DENTAL FEE SCHEDULE (Dental Procedures)
December 2015 (effective date 2-5-2016)
**** Please refer to the Oral Pathology Fee Schedule for pricing***
***** Please refer to Orthodontic Procedures for Pricing***

Proc Code		Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate
		Current Dental Terminology (CDT) coding definitions shall apply to all procedures/services		
		Any limit or prior authorization requirement established in 907 KAR 1:026 or 907 KAR 1:626 shall apply to this fee schedule		
D0120		PERIODIC ORAL EVALUATION ON AN ESTABLISHED PATIENT (1 per recipient per 12 months)	$27.50	n/c
D0140		LIMITED ORAL EVALUATION (LIMITED TO A SPECIFIC ORAL HEALTH PROBLEM OR COMPLAINT AND/OR DENTAL EMERGENCY) - **requires prepayment review - review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment**	$41.25	$41.25
D0145		ORAL EVALUATION FOR A PATIENT UNDER THREE (3) YEARS OF AGE AND COUNSELING WITH THE PRIMARY CAREGIVER.	$32.50	n/c
D0150		COMPREHENSIVE ORAL EVALUATION	$32.50	$32.50
D0190		SCREENING OF A PATIENT	**n/c**	**n/c**
D0191		ASSESSMENT OF A PATIENT	$25.00	**n/c**
D0210		INTRAORAL COMPLETE SERIES	$79.63	$61.25
D0220		INTRAORAL-PERIPICAL-FIRST FILM	$13.00	$10.00
D0230		INTRAORAL-PERIAPICAL-EACH ADDIT	$9.75	$7.50
D0270		BITEWING-SINGLE FILM	$11.38	$8.75
D0272		BITEWING-TWO FILMS	$22.75	$17.50
D0274		BITEWING-FOUR FILMS	$37.38	$28.75
D0330		PANORAMIC FILM **(REQUIRES PRIOR AUTHORIZATION AGES 5 AND UNDER)**	$48.75	$48.75
D0340		CEPHALOMETRIC FILM	$76.38	$58.75
D1110		PROPHYLAXIS-14 AND OVER	$60.13	$46.25
D1120		PROPHYLAXIS-13 AND UNDER	$60.13	**n/c**
D1206		FLUORIDE VARNISH	$18.75	**n/c**
D1208		TOPICAL APPLICATION OF FLUORIDE (limited to two per year)	$18.75	**n/c**
D1351		SEALANT - PER TOOTH (AGES 5-20)	$24.38	**n/c**
D1510		SPACE MAINTAINER-FIXED UNILATERAL	$169.00	**n/c**
D1515		SPACE MAINTAINER-REMOVABLE-BILATERAL	$328.25	**n/c**
D1520		SPACE MAINTAINER-REMOVABLE-UNILATERAL	$167.50	**n/c**
D1525		SPACE MAINTAINER-REMOVABLE-BILATERAL	$252.50	**n/c**
D2140		AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	$49.40	$38.00
D2150		AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	$65.00	$50.00
D2160		AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	$76.70	$59.00
D2161		AMALGAM-FOUR/MORE SURFACES, PRIMARY OR PERMANENT	$93.60	$72.00
D2330		RESIN-ONE SURFACE, ANTERIOR	$57.20	$44.00
D2331		RESIN-TWO SURFACES, ANTERIOR	$71.50	$55.00
D2332		RESIN-THREE SURFACES, ANTERIOR	$85.80	$66.00
D2335		RESIN-FOUR/MORE SURFACES, ANTERIOR	$101.40	$78.00
D2390		RESIN-BASED COMPOSITE CROWN	$101.40	**n/c**
D2391		RESIN-ONE SURFACE, POSTERIOR	$57.20	$44.00
D2392		RESIN-TWO SURFACES, POSTERIOR	$71.50	$55.00
D2393		RESIN-THREE SURFACES, POSTERIOR	$85.80	$66.00
D2394		RESIN FOUR OR MORE SURFACES, POSTERIOR	$101.40	$78.00
D2930		PREFAB STAINLESS STEEL CROWN-PRIMARY	$119.60	**n/c**
D2931		PREFAB STAINLESS STEEL CROWN-PERMANENT	$133.90	**n/c**
D2932		PREFAB RESIN CROWN	$113.10	**n/c**
D2394		RESIN FOUR OR MORE SURFACES, POSTERIOR	$119.60	**n/c**
D2951		PIN RETENTION-PER TOOTH, IN ADD. TO RESTOR	$13.00	$13.00
D3110		PULP CAP-DIRECT	$17.00	**n/c**
D3220		THERAPEUTIC PULPOTOMY	$67.60	**n/c**
D3310		ROOT CANAL THERAPY-ANTERIOR	$274.30	**n/c**
D3320		ROOT CANAL THERAPY-BICUSPID	$344.50	**n/c**
D3330		ROOT CANAL THERAPY-MOLAR	$481.00	**n/c**
D3410		APICOECTOMY-ANTERIOR	$201.50	$155.00
D3421		APICOECTOMY-BISCUSPID FIRST ROOT	$201.50	$155.00

DMS DENTAL FEE SCHEDULE (Dental Procedures)
December 2015 (effective date 2-5-2016)
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Proc Code		Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate
D3425		APICOECTOMY-MOLAR FIRST ROOT	$201.50	$155.00
D3426		APICOECTOMY-PER TOOTH EACH ADDIT ROOT	$197.00	$197.00
D4210		GINGIVECTOMY/GINGIVOPLASTY-FOUR OR MORE TEETH PER QUADRANT **(requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment)**	$336.70	$259.00
D4211		GINGIVECTOMY/GINGIVOPLASTY-ONE TO THREE TEETH PER QUADRANT **(requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment)**	$135.20	$104.00
D4341		PERIODONTAL SCALING AND ROOT PLANING-PER QUADRANT **(requires prior authorization)**	$101.40	$78.00
D4355		FULL MOUTH DEBRIDEMENT- procedure effective 9/30/2006 - LIMITED TO PREGNANT WOMEN ONLY	$68.50	$68.50
D5520		REPLACE MISSING/BROKEN TEETH-DENTURE	$40.30	**n/c**
D5610		REPAIR RESIN DENTURE BASE	$61.10	**n/c**
D5620		REPAIR CAST FRAMEWORK	$210.00	**n/c**
D5640		REPLACE BROKEN TEETH-PER TOOTH/DENTURE	$36.40	**n/c**
D5750		RELINE COMPLETE MAXILLARY DENTURE	$128.70	**n/c**
D5751		RELINE COMPLETE MANDIBULAR DENTURE	$128.70	**n/c**
D5820		INTERIM PARTIAL DENTURE (MAXILLARY)	$319.80	**n/c**
D5821		INTERIM PARTIAL DENTURE (MANDIBULAR)	$336.70	**n/c**
D5913		NASAL PROSTHESIS	$2,036.00	$2,036.00
D5914		AURICULAR PROSTHESIS	$1,881.00	$1,881.00
D5919		FACIAL PROSTHESIS	$3,408.00	$3,408.00
D5931		OBTURATOR (TEMPORARY)	$1,121.90	$863.00
D5932		OBTURATOR (PERMANENT)	$1,992.00	$1,992.00
D5934		MANDIBULAR RESECTION PROSTHESIS	$1,660.00	$1,660.00
D5952		SPEECH AID-PEDIATRIC (13 AND UNDER)	$2,036.00	**n/c**
D5953		SPEECH AID-ADULT (14 AND OVER)	$2,036.00	$2,036.00
D5954		PALATAL AUGMENTATION PROSTHESIS	$1,550.00	$1,550.00
D5955		PALATAL LIFT PROSTHESIS	$1,836.00	$1,836.00
D5988		ORAL SURGICAL SPLINT	$896.00	$896.00
D5999		UNLISTED MAXILLOFACIAL PROSTHETIC PROC **(requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment)**	**manually priced**	**manually priced**
D7111		CORONAL REMNANTS DECIDUOUS TOOTH	$49.40	$38.00
D7140		EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	$49.40	$38.00
D7210		SURGICAL REMOVAL OF ERUPTED TOOTH	$93.60	$72.00
D7220		REMOVAL OF IMPACTED TOOTH (SOFT TISSUE)	$127.40	$98.00
D7230		REMOVAL OF IMPACTED TOOTH (PARTIALLY BONY)	$179.40	$138.00
D7240		REMOVAL OF IMPACTED TOOTH (COMPLETELY BONY)	$215.80	$166.00
D7241		REMOVAL OF IMPACTED TOOTH (COMP BONY-UNUSUAL]	$222.30	$171.00
D7250		SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	$107.90	$83.00
D7260		OROANTRAL FISTULA CLOSURE	$135.20	$104.00
D7280		SURGICAL EXPOSURE OF IMPACTED/UNERUPTED **(requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment)**	**manually priced**	**manually priced**
D7310		ALVEOPLASTY IN CONJUN WITH EXTRACT/PER QUAD	$101.40	$78.00
D7320		ALVEOPLASTY NOT IN CONJ WITH EXTRACT/PER QUAD	$101.40	$78.00
D7410		EXCISION OF BENIGN SOFT TISSUE LESION LESS THAN 1.25 CM	$87.10	$67.00
D7411		EXCISION OF BENIGN SOFT TISSUE LESION GREATER THAN 1.25 CM	$87.10	$67.00
D7471		LATERAL EXTOSIS REMOVAL	$101.40	$78.00
D7472		REMOVAL OF TORUS PALATINUS UPPER ARCH (1 PER LIFETIME)	$302.47	$302.47
D7473		SURGICAL REMOVAL OF TORUS MANDIBULARIS	$209.28	$209.28
D7510		INCISION & DRAINAGE OF ABSCESS (INTRAORAL)	$67.60	$52.00
D7520		INCISION & DRAINAGE OF ABSCESS (EXTRAORAL)	$80.60	$62.00
D7530		REMOVAL OF FOREIGN BODY	$201.50	$155.00
D7880		OCCLUSAL ORTHOTIC DEVICE **(requires prior authorization)**	$424.00	**n/c**
D7910		SUTURE OF RECENT SMALL WOUND	$67.60	$52.00
D7960		SURGICAL FRENECTOMY (one)	$167.60	$129.00
D7960		SURGICAL FRENECTOMY (2nd one performed on same day)	$83.80	$64.50

DMS DENTAL FEE SCHEDULE (Dental Procedures)
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Proc Code		Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate
D8210		REMOVABLE APPLIANCE THERAPY **(requires prior authorization)**	$362.00	**n/c**
D8220		FIXED APPLIANCE THERAPY **(requires prior authorization)**	$259.00	**n/c**
D8660		PRE-ORTHODONTIC TREATMENT VISIT **(requires prior authorization) - and only if individual ultimately not approved for orthodontic treatment)**	$76.50 **	**n/c**
D8670		PERIODIC ORTHODONTIC TREATMENT VISIT	**n/c ****	**n/c**
D8999		UNSPECIFIED ORTHODONTIC PROCEDURE	**n/c ****	**n/c**
D9110		PALLIATIVE TREATMENT OF DENTAL PAIN	$27.30	$21.00
D9223		DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$75.00	$75.00
D9243		INTRAVENOUS MODERATE (Conscious) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$79.30	$79.30
D9410		EXTENDED CARE FACILITIES/HOUSE CALLS	$67.60	$52.00
D9420		HOSPITAL CALL	$67.60	$52.00
D9986		MISSED APPOINTMENT	**n/c**	**n/c**
D9987		CANCELLED APPOINTMENT	**n/c**	**n/c**
		n/c = not covered		
		*** Please refer to the Oral Pathology Fee Schedule for pricing**		
		**** Please refer to Orthodontic Procedures for Pricing**		
		Effective February 5, 2016		

DMS Dental Fee Schedule (Oral Pathology)
December 2015 (effective date 2-5-2016)

Proc Code	Procedure Description	Rate
DO472	Accession of tissue gross examination, preparation and transmission of written report ***(only covered if provided by an oral pathologist)***	$43.71
DO473	Accession of tissue gross and microscopic examination, preparation and trasmission of written report ***(only covered if provided by an oral pathologist)***	$61.81
DO474	Access of tissue , gross and microscopic examination including assessment of surgical margins for presence of disease, preparation and transmssion of written report ***(only covered if provided by an oral pathologist)***	$152.38
DO486	Laboratory accession of transepithelial cytologic sample microscopic examination and preparation and transmission of written report ***(only covered if provided by an oral pathologist)***	$35.44
DO475	Decalcification procedure ***(only covered if provided by an oral pathologist)***	$12.57
DO476	Special stain for microorganisms ***(only covered if provided by an oral pathologist)***	$71.03
DO477	Special stain not for microorganisms ***(only covered if provided by an oral pathologist)***	$71.03
DO478	Immunohistochemical stains ***(only covered if provided by an oral pathologist)***	$71.97
DO479	Tissue in-situ hybridization, including interpretation ***(only covered if provided by an oral pathologist)***	$55.43
D0482	Direct immunofluorescence **(only covered if provided by an oral pathologist)**	$52.09
DO484	Consultaton report on slides prepared elsewhere ***(only covered if provided by an oral pathologist)***	$52.09
DO485	Consultation report on referred material requiring preparation of slide ***(only covered if provided by an oral pathologist)***	$88.10
	n/c = not covered	

DMS Dental Fee Schedule - Orthodontic Procedures
December 2015 (effective date 2/5/2016)

Procedure Description/Practitioner
(1) A comprehensive orthodontic procedure shall be paid as follows:
(a) Except as established in (b) the rate for an orthodontic consultation including examination and treatment plan development shall be $112
*(b) The orthodontic consultation rate shall not exceed $56 if
1. provider determines comprehensive ortho procedures are not needed;
2. provider is unable or unwilling to provide needed ortho procedure(s); or
3. Prior authorization is not approved by the department or is not requested by provider
Reimbursement for a service for an early phase of moderately severe or severe disabling malocclusion shall be:
$1367 if provided by an orthodontist
$1234 if provided by a general dentist
Reimbursement for a service for a moderately severe disabling malocclusion shall be:
$1825 if provided by an orthodontist
$1659 if provided by a general dentist
A service for a severe disabling malocclusion:
$3000 if provided by an orthodontist
$2674 if provided by a general dentist
DMS Payment Process
Reimbursement for comprehensive orthodontic treatment shall consist of two (2) payments
1. The first payment shall be two-thirds of the prior authorized payment amount
2. The second payment shall:
a. Be one-third of the prior authorized payment amount; and
b. Not be billed or paid until six (6) monthly visits are completed following the banding date
3. The two (2) payments shall include all services associated with the comprehensive orthodontic treatment